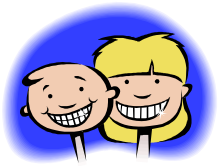
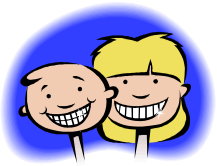


Open Wide Training Verification



Name _____

PS # or Date of Birth (mm/dd/yyyy) and last 5 digits of SSN

_____

Name of childcare business_____

Number of children enrolled_____

Module 1: Tooth Decay
Date Finished _____

Module 2: Risk Factors for Tooth Decay
Date Finished _____

Module 3: Prevention of Tooth Decay
Date Finished _____

Module 4: What to Do and How to Do It
Date Finished _____

Please return this form electronically to
HHSOralHealth@mt.gov
when you have completed the training.

THANK YOU.

SUBMIT

To verify that your form was sent
check your "send messages" folder.